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AUTHOR Gerber, Sterling K.
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ABSTRACT

Responsive therapy is an integrative model that uses a variety of intervention models, each in its own theory-pure context. This article addresses some major misdirections in the counseling profession and discusses ways that responsive therapy can help correct these misdirections. For at least two generations, counseling has professed that the client is important, knowledgeable, and capable of change. But due to a professional shift, these assumptions are no longer apparent in training or practice. Emphasis on a fulfillment bias has switched back to a medical model, seemingly dictated by the Diagnostic and Sta'istical Manual of Mental Disorders and third-party payment restrictions, which has been accompanied by a certain rigidity in counseling practices. Responsive therapy permits intentional responsiveness to unique client circumstances and styles while delivering service in a theory-pure, maximally effective manner. This integrational approach answers both the criticism of inflexibility of unidirectional discipleship approaches and the lack of consistency in theory-poor eclecticism. Similarly, this approach removes diagnosis from therapy, allowing for its importance in accounting, research, and in staffing cases, while avoiding the ills of pejorative labeling and categorical treatments. (RJM)

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Responsive Therapy: An Integrational Approach

Sterling K. Gerber

Eastern Washington University

Abstract: The author revisits the disciple versus eclectic issue in the present context of a professional shift from emphasis on a fulfillment bias back to a medical model, seemingly dictated by DSM IV and third-party payment restrictions. An alternative approach is presented which permits intentional responsiveness to unique client circumstances and styles while delivering service in a theory-pure, maximally effective manner. This integrational approach answers both the criticism of inflexibility in discipleship and the lack of consistency in theory-poor eclecticism. Similarly, this approach removes diagnosis from therapy, allowing for its importance in accounting, research, and in case staffings, while avoiding the ills of pjorative labelling and categorical treatments.

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This article addresses some major misdirections in the counseling profession. One is not likely to arrive where he or she wishes to be unless a direction is chosen. It is no less true that specifying a goal is useless if its articulation is followed by procedures that lead in mutually exclusive directions.

For at least two generations, counseling has professed an identity with the client; the client is important, knowledgeable, and capable of movement from self-defeating to self-enhancing actions. No longer is that apparent in training nor in practice. The profession appears to have moved full circle from reliance on a medical model--assess, diagnose, prescribe, treat--to a fulfillment model of establishing a facilitative environment in which the client engineers his or her own change, and finally right back to a medical model. The strengths and weaknesses of a medical model remain much as they were in the 1930's; the strengths and weaknesses of the fulfillment model also continue, unchanged. It makes no sense for the profession to cycle between the two when a superior option is available.

This paper begins with some assertions--statements that establish a point of departure or a bias. Unlike formal logic, these are not givens to be accepted; they are postulations to be supported.

Some pertinent assertions are:

1. To be eclectic is to be irresponsible.
2. Diagnosis is not a part of therapy.
3. The DSM IV is a potentially dangerous diversion.
4. Technique follows understanding.
5. Responsive Therapy is a superior approach.

What is Responsive Therapy? It is an integrative model that purports to structure the use of a variety of intervention models, each in its own theory-pure context. It is firmly based in phenomenology. Beginning with a phase that relies on critical, universal therapy skills, therapy proceeds through a highly active, hopefully collaborative, intervention phase. It espouses avoidance of the DSM IV trap. The underlying theory, universal skills, and a frame for identification of client style and circumstance, as well as a nomenclature for categorizing extant therapeutic models, are presented in Gerber (1986).

The Irresponsibility of Eclecticism

What is eclecticism and why are its practioners irresponsible? To be eclectic is "not following any one system, as of philosophy, medicine, etc., but selecting and using whatever is considered best in

all systems" (The American College Dictionary). In counseling, eclecticism can be seen as the practice of drawing a mixture of techniques from any/all theoretical persuasions and combining them in unique, creative, or comfortable ways. The rationale for labelling such a practice as irresponsible is that, by its very nature, an eclectic approach is not integrated by theory. It is technique rich, theory poor. A Gestalt principle says that meaning comes from the context; an extension of this principle suggests that the power of an intervention technique comes from the theoretical context in which it is embedded. To take the technique out of context is to weaken or disable it. In practice, the most frequent manifestation of irresponsibility is in the following up of a potentially effective technique with another which counters the first. Examples include verbal encouragement or even statements of disappointment when a client fails to achieve a reinforcer in a contingency management program or when progress is being made with a cognitive therapy confrontation only to be destoyed by the direction to descend back into the depression in response to, "Tell me what you are feeling now."

Some personal professional history will serve to elucidate the issue and set the foundation for the earlier description of the

profession coming full circle. For the graduate student in the fifties, the therapeutic training mileu had three prongs. Williamson's Directive Therapy was firmly established and was, perhaps, the traditional approach. It was basically the medical model applied to counseling. The therapist is wise and knowing; clients need direction to overcome their problems; the process is assess--diagnose--prescribe/treat. Rogers presented a different frame for interpreting the client and the dynamics of therapy. Given a facilitative emotional environment--genuine, non-judgmental, non-restrictive--clients would martial their own resources in their own behalf and "cure" themselves. A third option was available for therapists who couldn't/wouldn't conform to either of the other two choices: Thorne's Eclectic Therapy. In reality, my training program was somewhat schizoid in its emphasis on non-directive techniques and theory base while requiring considerable facility in psychometric skills. In essence, the message was to be eclectic, yet one particularly strong-spoken, and apparently influential faculty member, said, "Do not be eclectic! It's theory-weak! Be a disciple and learn well your chosen way."

The dilemma for me and for other students of therapy was that we were being trained in a mixed model, taught to call ourselves Rogerian and to avoid eclecticism, and turned loose on a practical world that provided even less consistent expectations. There were many "closet eclectics" at that time. When there are major deficiencies in the two major approaches and an even larger weakness in the eclectic alternative, there is a high degree of cognitive dissonance. The resolution to the dilemma of avoiding eclecticism because it is ineffectual and avoiding restriction to any one discipleship because it is unnecessarily limited is to adopt an integrational model, Responsive Therapy, one that structures the use of many intervention models, each in a theory-pure context.

Appearances suggest a similar condition today to that of the fifties, but with the poles reversed. The increasing expectation/demand for accountability coupled by a questionable priority for doing labels over doing therapy has re-established the preference for the medical model. It is no longer permissable to be non-directive; such does not establish the therapist as accountable. Of course the major theoretical and philosophical base of the traditional client-centered approach is to leave the accountability to

the client; the counselor's function is to create the environment that supports change. There appears to be a clinging to the relationship principles and the "active listening" techniques of the recent professional past while, at the same time, a premium is placed on intake assessment and DSM IV determinations.

Diagnosis is not a part of therapy.

If the objective is to gather "objective" data in order to select the most appropriate diagnostic category in order to assign the related therapeutic answer, why spend time in mapping the client's phenomenal space? The two activities are philosophically opposed. A further manifestation of the new schizoid nature of counseling is the maxim to "Make your client a partner in the therapeutic process." If diagnosis truly is a professional function based on assessment and decision, then use of psychometric devices and lengthy intake forms that cover all of the possibilities (the traditional clinical approach) is the only defensible position. This is underscored by the nature of a litigious society which necessitates "CYA" tactics. There is no need to invest hours in finding what the client thinks, feels, or believes; to do so works against another pressure, that of the third-party payor that frames therapy in ten session episodes.

An alternate perceptual frame may be useful in sorting out this confusion. If diagnosis and therapy are seen as different functions, separate and related, then both can be accomplished more effectively. In diagnosis mediated therapy there are two stages: (1) intake and assessment directed at identifying a diagnostic category, and (2) treatment appropriate to the assigned diagnostic category. In contrast to the two stage treatment model, Responsive Therapy involves two or three sessions where the counselor and client explore progressively more specific examples of client experience, arriving at descriptions of client circumstance and style. Intervention is an extension of those descriptions, applied in ways that are most responsive to the unique and special conditions pertaining to each particular client. This permits or enhances a client-counselor partnership in all aspects of therapy.

Diagnostic categories are most useful as a relatively descriptive summary of condition and treatment. Such categorical descriptions make accounting and research less cumbersome. They are useful in educational and case staffing proceedings, though not as powerful as client experiential vignettes, which provide primary data rather than processed data.

The DSM IV is a potentially dangerous diversion.

There are two problems arising out of an emphasis on diagnostic category-driven therapy. One is the tendency to lose sight of the client's uniqueness, to distort perception of circumstance and style. Another is the economically driven tendency either (1) to fit clients into categories which are marginally appropriate, if accurate at all, in order to justify payment from third-party payors, or (2) to create progressively more and broader categories in order to accomodate a wider population of treatable (pay-for-able) clients. The latest revision of the DSM has an increased number of categories which incorporate a population of clients whose "maladies" reach closer to normality than was true with previous iterations.

Relative to the first problem of diagnosis mediated therapy, in the 1995 Evolution of Psychotherapy Conference sponsored by the Milton Erickson Foundation, prominent leading therapists said things like, "The DSM is 90% nonsense," "When I'm in therapy with a client, I don't pay much attention to categories and structures. I focus on client dynamics," and "When it doesn't work, do something else--even if you don't believe in it." These statements underscore the importance of responsiveness to the immediate client interaction

over consideration for diagnostic categories, practised interpretations, and preferred intervention strategies. When the therapist is overly concerned with her or his own arriving at conclusions, it is very easy to lose the client. In the attempt to fit a client into a slot, it is too easy to find what the therapist is looking for and to overlook or ignore important qualifying perceptions.

In some clinical settings, the newest counselors spend an inordinate amount of time doing intake interviews with the objective of arriving at a DSM-IV categorical diagnosis. Those who are less experienced at perceiving important qualifying data and whose success depends on coming up with diagnostic conclusions presumably are making decisions which drive the interventions for the clients. Such dynamics increase the liklihood of losing unique and significant aspects of the clients and pointing therapy in questionable directions.

The second problem grows out of a societal or political perception that there is a dichotomy in mental health with only two categories: mentally healthy and mentally ill. Unlike third-party procedures in physical health where prevention is a legitimate expense, the politics of treatment in mental health have justified expenditures only for "certifiable" cases; i.e., those for whom a DSM

category exists. For a great proportion of clients who are struggling with developmental asynchrony or normal yet disruptive crises of living, there are no entries in the book of certifiable illnesses. In order to provide access to therapy for a large number of people who can ill afford it, therapists have justified clinical labels, with a bias to calling the condition severe. This is a double bind for counselors who are faced either with overstating the client condition to provide support for therapy or turning many clients away. The American Psychiatric Association has ameliorated this condition somewhat by endorsing the DSM-IV, a reference list which is more inclusive of a broader range of client conditions.

Menninger, Mayman, and Pruyser (1963) chronicled a strong case against pjorative labelling, the problem that occurs when a diagnostic label becomes pre-eminent in definition of a person, both by others and by the self. Too much emphasis on the label can be a detriment to sensitively applied interventions.

The current dilemma contrasts sensitivity to client reality (phenomenological) with accountability of therapeutic interventions (neo-clinical). For therapists who are unwilling to give up their client-centered roots, yet are required to meet externally imposed

demands of agency funding, medical insurance plans, and health maintenance organizations, their approach becomes ineffectually eclectic. There appears to be value in separating the treatment and the diagnostic functions. There appears to be wisdom in letting client dynamics supercede those dictated by the DSM-IV.

Technique follows understanding.

This heading is attributable to Rollo May. It posits a relationship between problem and resolution, illness and cure, with the latter being most efficiently a response to the former. Borton (1970) expresses the same dynamics in his description of a cognitive processing model. He says that there is a directional and causal relationship between observation, interpretation, and reaction. In a therapeutic context, the observations of the counselor as he or she helps the client expand awareness of client phenomenal reality are the foundation. The sense made of those observations through some form of systematic interpretation creates a context for the selection or creation of procedures to bring about desired change. The change procedures are effective only to the extent that they reflect the dynamics of the interpretation, which in turn is valid only if it reflects the dynamics made apparent by the observations.

Each application of an intervention strategy must rest on a system of interpretation. This interpretational system must be an extension of the unique circumstance and style of the client who is to benefit from the intervention. Observation, interpretation, application are integrally related in the Gestalt of a successful therapeutic interaction.

Responsive Therapy is a superior approach.

Escape from the recurrent dilemma, the vascillation between the medical model and the fulfillment model, may be made by subscription to an integrative approach. It is possible to separate aspects or sequences of the counseling process and treat each in a logical, theory-pure, and effective way. Frequently the strategy for solution of client problems is to separate out or isolate one problem from others which obscure its identity and resolution. Similarly, separation of therapy into interdependent units may provide simplicity and elegance of management. Responsive Therapy prescribes the following subdivision:

1. Remove diagnosis from therapy. Diagnosis can be framed honestly as a management technique, useful in codifying clients for relative ease in computer accounting, research groupings, insurance

reimbursement, and esoteric case staffings. Diagnostic labels are not particularly useful as indicators of intervention strategies. Each client must be approached in sensitive and often unique ways; therefore, the imposition of a label between assessment and intervention can only introduce a degree of insensitivity and error in the therapeutic process. Once we accept diagnosis as a product of therapy, not a facet or integral dynamic, then we can perform it more efficiently. Clients will be served better by a policy of "least restrictive labels" thus reducing the potential damage of pjorative labels.

2. Accomplish initiation, ventilation, and clarification through reliance on universal counseling skills; explore client phenomenal reality in order to identify client circumstance and style. The Sequential Initiating, Tracking, and Enhancing (SITE) skills of Responsive Therapy are a compilation of commonly used techniques for accessing client experience. They include Indirect Lead, Paraphrase of Content, Summary of Content, Traffic Signs, Structure of Content, Paraphrase of Message, Reflection of Feeling, Formalization of Non-verbal Cues, Description of Situation, Summary of Messages, Silence, Touch, Pacing, Minimizing of Interrogation, and

Process Control. This phase requires typically two or three sessions and leads to the next step.

3. Describe client circumstance and style according to their cognitive, affective, and behavioral characteristics. Circumstances or "problems" can be described according to their surplus (too much or incorrect) or deficit (absence or deficiency) nature. Surplus cognitions are the presence of beliefs that are inaccurate hence self-defeating; such are readily amenable to cognitive restructuring. Deficit cognition is ignorance of useful or necessary information; information exchange, teaching, or bibliotherapy are indicated. Surplus affect includes, for example, pent-up emotions or lack of training in recognizing and expressing emotional states; ventilative and expressive interventions are useful. Affective deficit results from long-term lack of personal validation; relationship therapies are most appropriate and most efficient for this state. Behavioral surplus is the presence of self-defeating habits; behavioral deficit is the absence of self-enhancing habits; operant techniques for the decrease, extinction, installation, or increase of situationally cued responses are especially useful here. Parenthetically, length of

therapy will be a function of the type of intervention and not dictated by payment organizations.

Clients tend to approach their conditions with preferences that may be classed in the same dynamic categories. Some tend to be deliberative and contemplative (cognitive). Some are intuitive (affective). Some are reactive (behavioral). Knowing client style makes it possible to (a) appeal to that style in seeking resolution, (b) confound that style if it is obtrusive, or (c) teach another style which may more completely address problem resolution.

4. Selection of active intervention strategies derives from understanding the client style and circumstance. Technique follows understanding. The unique interplay between elements in the client's circumstance and style forms the equasion for problem resolution. What will work is an extension of what is present or what is critically absent in the interplay between circumstance and style. Once this is described, therapy proceeds into an active, dynamic, theory-based approach. At this juncture, clients may be enlisted in their own therapeutic process; therapists may become selectively directive, prescriptive, confrontational, active, interactive or whatever else is indicated by the described dynamics of circumstance

and style and is within professional and ethical boundaries. The critical assessment of dynamics and the selection of the intervention having the highest probability of success enables the therapist to be intentional, forceful, systematic, accountable, and effective because therapy is proceeding toward a goal and in a theory-pure context.

There are, of course, client complexities that include the presence of problems from more than one category, and client styles that are mixed. There are conditions of internal incongruity and external ambiguity. Sometimes it is necessary to serialize therapy; i.e., resolve one problem with one theory-pure intervention before proceeding to a different problem and different intervention. It is possible to involve a colleague and engage in multiple therapies at the same time. The strength of the model is in isolating problem dynamics and client penchants so as to organize efficient interventions.

It is not suggested that a therapist be all things to all people. Rather it is proposed that the therapist be different things to different people; i.e., a behaviorist for a person with behavioral surpluses or deficits, a teacher to the ignorant, an anchor for the affectively detached, etc. Of great importance is that the therapist

be what is needed at the time and for the individual client, that the intervention be pure. Like the unknown or counterproductive effects of mixed medications, mixed therapies hold high potential for neutralization or damage.

Professional accountability requires that therapists know what is effective and appropriate for what condition or circumstance of each particular client, and that they perform or facilitate its happening in assertive and efficient ways. Responsive Therapy provides a philosophy and a structure for enhancing such accountability.

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